October 25, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

MDR Tracking #: M2-05-0169-01
IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Anesthesia and Pain Management. The reviewer is on the TWCC ADL. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient is approximately a 30 year old female who complains of neck pain radiating to both arms on occasion. She has a history of neck pain, which began after a work-related accident approximately ___ ago. This pain had been present, but not as severe as it is now. On ___, the patient was at work and was asked to move some boxes and began to experience neck pain. This pain became much more severe, and because of the severe neck pain, the patient has been unable to work.

Records reviewed include:
1. The patient's physician records for numerous states in August of 2004 and September of 2004.
2. Workmen's compensation initial report dated 7-23-2004 by ___. This doctor is a pain specialist.

3. An MRI report of the cervical spine dated 7-29-2004, with impression of spondylosis at C5-C6 and bulging disc with cord contact and ventral surface flattening. At C5-C6, there is foraminal narrowing, and at C6-C7, there is a bulging disc.
4. An MRI report of the cervical spine dated 7-29-04 by ___ with impression of a herniated disc at T11-T12.
5. A pain clinic consult dated 8-11-04.
6. A psychiatric interview dated 9-3-04 by ___.
7. A consultation by ___, an orthopedist.
8. A nerve conduction report of the upper extremities and an initial consultation by ___ dated 9-16-04.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a cervical epidural steroid injection at C5-7.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states this is the standard of care. The patient has pain in the distribution of the bulging disc as demonstrated in the MRI of the cervical spine. This patient has undergone conservative therapy, including non-steroidal anti-inflammatories, physical therapy, and other oral medications without any relief.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 25th day of October 2004